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A. Type of Handbook

Part H, Division VI, is the provider-specific Medicaid handbook for mental health crisis intervention (hereafter referred to as “crisis intervention”) services. Refer to Section II of this handbook for a definition of crisis intervention services. Part H, Division VI, includes information for providers on provider eligibility criteria, recipient eligibility, covered services, payment methods, and billing instructions. Use this handbook in conjunction with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for general policy and regulation information for AFDC/Healthy Start recipients enrolled in a Medicaid Health Maintenance Organization (HMO).

B. Provider Information

Separate Provider Certification Required

Wisconsin Medicaid may pay only county or tribal agencies to provide crisis intervention services as stated in Section 49.45 (41), Wis. Stats. County or tribal agencies, or the agencies the county or tribal agencies contract with to actually provide crisis intervention services, must be certified under HFS 34, Subchapter 3, Wis. Admin. Code.

Wisconsin Medicaid requires the county or tribal agency, and all agencies the county or tribal agency contracts with to provide crisis intervention services, to have separate Medicaid crisis intervention certification. Crisis intervention providers may not use provider certification numbers used for other services, such as community support program (CSP) services, to bill Wisconsin Medicaid for crisis intervention services.

Information for County/Tribal Agencies

To receive Medicaid reimbursement for crisis intervention services, county or tribal agencies must obtain Medicaid certification for billing purposes, even if the county or tribal agency is not a direct provider of crisis intervention services.

Upon Medicaid certification, the county or tribal agency will receive a Medicaid billing provider number. The Medicaid billing provider number indicates that the entity is Medicaid-certified and is responsible to ensure that all Medicaid requirements are met when services are provided. Wisconsin Medicaid sends all payments to the entity that has the Medicaid billing provider number.

Only the county or tribal agency may be the billing provider because the billing provider is responsible for providing the local matching funds for crisis intervention services. Wisconsin Medicaid will certify only one such matching funds agency per county but will certify multiple performing providers per county.

NOTE: Wisconsin Medicaid will certify two billing providers for one county if one is an allowable county agency and one is a tribal government agency.

Refer to the claim form instructions in Appendix 2 of this handbook for information about how to bill for crisis intervention services using the county or tribal agency’s Medicaid billing number.

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B. Provider Information
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County or Tribal Agencies That Also Provide Services

County or tribal agencies that provide crisis intervention services must receive a Medicaid non-billing performing provider number in addition to a billing provider number. Wisconsin Medicaid uses this number to ensure that agencies performing crisis intervention services meet the standards under HFS 34, Wis. Admin. Code, and all Medicaid-covered service requirements.

Wisconsin Medicaid does *not* use the non-billing performing provider number to send Medicaid payments. Refer to the claim form instructions in Appendix 2 of this handbook for information about how to bill for crisis intervention services using the county or tribal agency's non-billing performing provider number.

Note: If you are initially Medicaid-certified as a crisis intervention billing provider only, and, at a later date, you are seeking certification as a non-billing performing provider, you must request a non-billing performing provider number from the Medicaid fiscal agent, EDS. Refer to Appendix 7 of this handbook for the Request for a Non-Billing Performing Provider Number form. The Medicaid non-billing performing provider number indicates that the entity is Medicaid-certified and HFS 34-certified.

Crisis Intervention Providers Contracting With County or Tribal Agencies

Crisis intervention providers contracting with a county or tribal agency receive only a non-billing performing provider number. Crisis intervention providers need approval from the county or tribal agency to obtain Medicaid certification and to bill Wisconsin Medicaid. Also, the crisis intervention provider must coordinate billing with the county or tribal agency.

Wisconsin Medicaid sends all payments to the county or tribal agency listed on the claim form. Refer to the claim form instructions in Appendix 2 of this handbook for information about billing for crisis intervention services as a crisis intervention provider who contracts with a county or tribal agency.

Individual staff do not require certification to provide crisis intervention services. However, clinical staff must meet requirements under HFS 34.21, Wis. Admin. Code.

Application for Certification

For information regarding certification under HFS 34, Wis. Admin. Code, contact:

Program Certification Unit
Bureau of Quality Assurance
Division of Supportive Living
P.O. Box 7851
Madison, WI 53707-7851

For information regarding Medicaid certification, contact:

Provider Maintenance
EDS
6406 Bridge Road
Madison, WI 53784-0006

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B. Provider Information
(continued)

Scope of Service

The policies in Part H, Division VI, govern services provided within the standards defined in HFS 34, Wis. Admin. Code. Refer to Section II of this handbook for covered services and related limitations.

Payment Methods

Medicaid reimbursement is based on a fixed hourly rate. The federal share of this rate is the *hourly* amount the provider receives from Wisconsin Medicaid.

Wisconsin Medicaid has established interim uniform contracted rates for crisis intervention services. In 1998, Wisconsin Medicaid will develop crisis intervention cost reports for the community service deficit reduction benefit (CSDRB) to determine a county's actual cost to provide crisis intervention services. Counties certified as billing providers will receive a cost report to complete. This cost report will serve as the basis for determining the county's actual cost to provide crisis intervention services. Counties will be eligible to receive the federal share of their actual cost to provide crisis intervention services subject to applicable federal limits. Counties will need to certify that they have contributed the local share using public funds eligible for federal financial participation.

Refer to Appendix 5 of this handbook for clarification on matching fund requirements. Refer to Appendix 2 for billing instructions.

Provider Responsibilities

Refer to Section IV of Part A, the all-provider handbook, for provider responsibilities and for information about:

- Fair treatment of the recipient.
- Maintenance of records.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.
- Grounds for provider sanctions.
- Additional state and federal requirements.

C. Recipient Information

Verifying Recipient Eligibility

Eligible Medicaid recipients receive identification cards monthly that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and, when applicable, an indicator of health insurance, HMO, and Medicare coverage.

Note: Check the recipient's identification card *before* providing service to determine recipient eligibility and any limitations to the recipient's coverage.

Section V of Part A, the all-provider handbook, provides detailed information about eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and eligibility verification. Review Section V of Part A, the all-provider handbook, *before* providing services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

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**C. Recipient
Information**
(continued)

Copayment

Wisconsin Medicaid does not require copayment for crisis intervention services.

Recipients Enrolled In Managed Care Programs

Providers must check the recipient's current identification card for managed care program coverage before providing services. Recipients enrolled in a Medicaid-contracted managed care program receive a yellow identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. Refer to Chapter 4 of the Provider Section of the Wisconsin Medicaid Managed Care Guide for the HMO Medicaid ID codes.

For recipients enrolled in a Medicaid managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization for crisis intervention services.

Except for recipients enrolled in the Wraparound Milwaukee program, Wisconsin Medicaid denies claims submitted to the fiscal agent for crisis intervention services provided to a recipient enrolled in a Medicaid managed care program. Refer to next page of this handbook for more information on specialized managed care programs.

Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for more information about managed care program noncovered services, emergency services, and hospitalizations.

Crisis Intervention and Medicaid Managed Care

AFDC/Healthy Start HMOs

All HMOs serving the AFDC population must have a Memorandum of Understanding (MOU) with each county's responsible human service department or board created under s. 51.42, Wis. Stats. in their service area. This MOU must address coordination of care for common clients. If the county is also a service provider, payment for service issues may be addressed through the MOU or a formal provider contract.

HMOs serving the AFDC population must reimburse non-HMO providers for emergency mental health or AODA treatment services if the time required to obtain such treatment at the HMO's facilities would have risked permanent damage to the enrollee's health or safety, or the health or safety of others.

When appropriate emergency treatment is provided by a non-HMO provider to an HMO enrollee, the non-HMO provider must notify the HMO within 72 hours of initiating services. The HMO is liable for the cost of the first 72 hours of care.

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- C. Recipient Information** The HMO's liability for appropriate emergency treatment is the current Medicaid fee-for-service rate for such treatment. Upon notification within 72 hours, the HMO is responsible for payment of additional care only if given the opportunity to provide such care.
(continued)

Specialized Managed Care Programs

Crisis intervention is separately reimbursable on a fee-for-service basis for the Wrap-around Milwaukee program only. Providers may identify Wraparound Milwaukee recipients by the code "MCPWAM" in the "Other Coverage" section of the Medicaid identification card, and the sentence, "Mental Health Services Only Thru WAM," listed above the recipient's name and address on the ID card. For all other specialized managed care programs, providers must seek reimbursement directly from the managed care program. Wisconsin Medicaid encourages crisis intervention providers to contact managed care providers in their area to discuss how to handle mental health crisis situations.

Crisis Intervention and Community Support Programs (CSP)

Wisconsin Medicaid covers crisis intervention services for individuals receiving Medicaid-funded CSP services when:

- The crisis intervention program has a formal arrangement with the CSP to provide crisis services to CSP enrollees.
- The crisis intervention services are delivered according to a crisis plan developed by the crisis intervention program and the CSP.
- The crisis intervention services do not duplicate CSP services.

NOTE: The crisis intervention program may not claim Medicaid reimbursement if reimbursement for the crisis intervention services is claimed through the CSP.

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A. Introduction

Definitions

Wisconsin Medicaid uses the following definitions:

1. “*Crisis*” means “a situation caused by an individual’s apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual” [HFS 34.02 (5), Wis. Admin. Code].
2. “*Crisis Plan*” means “a plan prepared under s. HFS 34.23 (7) for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person’s individual service needs” [HFS 34.02 (6), Wis. Admin. Code].
3. “*Emergency mental health services*” means “a coordinated system of mental health services which provides an immediate response to assist a person experiencing a mental health crisis” [HFS 34.02 (8), Wis. Admin. Code].
4. “*Response Plan*” means “the plan of action developed by program staff under s. HFS 34.23 (5) (a) to assist a person experiencing a mental health crisis” [HFS 34.02 (20), Wis. Admin. Code].
5. “*Stabilization Services*” means “optional emergency mental health services under s. HFS 34.22 (4) which provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization” [HFS 34.02 (21), Wis. Admin. Code].

B. Covered Services

What Is Crisis Intervention?

Crisis intervention services are services provided by an emergency mental health services program to an individual in crisis or in a situation that may develop into a crisis if professional supports are not provided. All crisis intervention services must conform to the standards in HFS 34, Subchapter 3, Wis. Admin. Code. References to appropriate sections of HFS 34, Wis. Admin. Code, in this handbook are identified in parentheses. Refer to Section IB, of this handbook for information on how to obtain more information about provider certification under HFS 34, Wis. Admin. Code.

Recipient Eligibility for Crisis Intervention Services

Wisconsin Medicaid covers an initial contact and assessment for any recipient contacting the crisis intervention provider. For recipients not in a crisis, the length of the assessment must be no longer than what is required to determine that no crisis or emergency exists and to make appropriate referrals, when indicated.

Wisconsin Medicaid covers all other crisis intervention services only if the provider documents that both of the following are true:

- The recipient is in a crisis or in a situation that may develop into a crisis if professional supports are not provided.
- The provider can expect to reduce the need for institutional treatment or improve the recipient’s level of functioning.

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B. Covered Services
(continued)

Wisconsin Medicaid covers crisis intervention services for recipients being discharged from an institutional setting (hospital or nursing home) only if the provider documents the following in the recipient's records:

- Why the recipient is likely to experience an emergency or a crisis if the crisis intervention services are not provided.
- Why other services that might maintain the recipient in the community are not available and when such services are likely to be available.

Recipients are not eligible for any Medicaid services during periods of time when they are in jail or secure detention.

General Requirements

Wisconsin Medicaid covers crisis intervention services when all the requirements in this section are met.

Providers may provide crisis intervention services by the following means:

- Over the telephone.
- In person at any location where a recipient is experiencing a crisis or receiving services to respond to a crisis.

Providers must document the means and place of service in the recipient's record.

Travel and Recordkeeping Time

Wisconsin Medicaid covers staff travel time to deliver covered crisis intervention services and the recordkeeping time associated with delivering the services. Travel and recordkeeping are not separately billed. They are billed as part of the covered service. That is, the provider adds up the service time, travel time (if any), and recordkeeping time, and bills this total when billing for a service.

Example: If a provider spends 20 minutes travelling to a recipient, 1 hour providing covered crisis intervention services, and 5 minutes completing recordkeeping associated with those services, the provider must bill all of this time together (as 1.5 billing units) on the HCFA 1500 claim form. Refer to Appendix 6 of this handbook for guidelines for rounding time and for the appropriate billing units for crisis intervention services. *NOTE:* Travel time is not covered if no covered service was provided.

Multiple Crisis Intervention Staff and Staff Time

Wisconsin Medicaid covers more than one staff person providing crisis intervention services to one recipient simultaneously if multiple staff are needed to ensure the recipient's or the provider's safety (e.g., the recipient is threatening to hurt others). Providers must clearly identify the number of staff involved when billing for more than one staff person and the rationale for multiple staff in their documentation.

Refer to the billing section (Section III) of this handbook for information about how to bill for multiple staff.

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B. Covered Services
(continued)

Crisis Service Hours

Wisconsin Medicaid covers only services that are directed toward solving and preventing crises under the crisis intervention benefit. Providers must use the crisis plan or response plan to document how services are related to these goals.

For services meeting the above criteria, Wisconsin Medicaid does *not limit* the number of crisis service hours that may be reimbursed through the claims system for services provided to a recipient per day. Also, there is no limit on the length of time that crisis services are covered for a given recipient. Providers must use the response and crisis plans to document service needs and to justify the need for continued services.

Wisconsin Medicaid monitors the use of crisis intervention services retrospectively through data analysis and auditing.

Crisis Intervention Covered Services

Initial Assessment and Planning

This service includes the following:

- The initial contact and assessment [HFS 34.23 (3) and (4), Wis. Admin. Code], including referral to other services and resources, as necessary, when further crisis intervention services are not required.
- The response plan's development per HFS 34.23 (5), Wis. Admin. Code, when required.

Crisis Linkage and Follow-Up

Crisis linkage and follow-up include the following:

1. Reviewing and updating the response plan and development, review, and updating of the crisis plan.
2. Follow-up interventions prescribed in a response plan or crisis plan or other interventions approved by a psychiatrist or psychologist to meet the following goals:
 - Relieve the recipient's immediate distress in a crisis or pre-crisis.
 - Reduce the risk of a worsening crisis.
 - Reduce the level of risk of physical harm to the recipient or others.
 - Resolve or manage family crises to prevent out-of-home placements of children, improve the child's and family's coping skills, and assist the family in using or obtaining ongoing mental health and other supportive services.
 - Assist the recipient in making the transition to the least restrictive level of care.
3. Linkage activities designed to:
 - Provide evaluation, referral options, and other information to a recipient or others involved with the recipient.

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B. Covered Services
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- Coordinate the resources needed to respond to the situation.
- Assist in the recipient's transition to the least restrictive level of care required.
- Follow-up to ensure that intervention plans are carried out and meeting the recipient's needs.
- Resolve or manage family crises to prevent out-of-home child placements, improve the child's and family's coping skills, and help the family use or obtain ongoing mental health and other supportive services.

Crisis Stabilization Services

Crisis stabilization services include professional supports identified on the response plan or crisis plan provided in any of the following settings (list is not all-inclusive):

- Adult family home.
- Child caring institution.
- Community-based residential facility.
- Crisis hostel.
- Foster or group home.
- Outpatient clinic.
- Person's home.
- School.

When professional staff of the crisis intervention program who are not staffing a 24-hour in-residence stabilization program provide stabilization services, the crisis intervention program must bill stabilization services using the procedure codes for crisis stabilization listed in Appendix 3. Wisconsin Medicaid reimburses these codes on an hourly basis. Wisconsin Medicaid covers only those stabilization services necessary for:

- Reducing or eliminating an individual's symptoms of mental illness so that the person does not need inpatient hospitalization.
- Assisting in the transition to a less restrictive placement or living arrangement when the crisis has passed.

Services Covered for Recipients in Inpatient Hospitals and Nursing Facilities

The only services covered for recipients in an inpatient hospital or a nursing facility are:

- Development of a crisis plan.
- Services to assist the recipient in making the transition to a less restrictive level of care.

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B. Covered Services
(continued)

Approval of Covered Services

A psychiatrist or a licensed psychologist listed, or eligible for listing, in the National Register of Health Care Providers in Psychology must approve all services *except*:

- Initial contact and assessment, including the initial response plan's development.
- Crisis or response plan reviews.
- Crisis or response plan updates.

The psychiatrist or psychologist must document his/her approval with one of the following methods:

- Signing the crisis plan.
- Signing the response plan.
- Signing or cosigning contact notes.

Response Plan

According to HFS 34.23 (5), Wis. Admin. Code, a psychiatrist or licensed psychologist must approve the initial response plan within five working days after services are first delivered. After the initial response plan has been approved, signed, and implemented, the psychiatrist or licensed psychologist must review and sign the response plan at least monthly, even if changes are made more often. Wisconsin Medicaid covers all services identified on the response plan which meet the covered services requirements outlined in this section if the response plan has been reviewed and updated and signed by a psychiatrist or licensed psychologist within the past month.

Crisis Plan

Wisconsin Medicaid covers services identified on the crisis plan that meet the covered services requirements outlined in this section if the crisis plan has been reviewed and updated and signed by a psychiatrist or licensed psychologist within the past six months. The psychiatrist or licensed psychologist must review and sign the crisis plan at least only once every six months, even if changes are made more often.

Contact Notes

The psychiatrist or licensed psychologist must sign a contact note within five working days of when the documented service was provided. The psychiatrist or licensed psychologist does not need to sign individual contact notes if the service provided was identified on a response plan or crisis plan which the psychologist or psychiatrist signed according to the requirements noted in *Response Plan* and *Crisis Plan*.

Documentation

In addition to the requirements under HFS 105.02 (4) and (6) and 106.02 (9), Wis. Admin. Code, providers must maintain documentation of staff qualifications per HFS 34.21 (3), Wis. Admin. Code.

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B. Covered Services
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Throughout the recipient's records, documentation must include whether the contact with the recipient and others was a personal, phone, or written contact. If the contact was a personal contact, documentation must include the location where the personal contact was made. Recipients' records must contain the following types of documentation:

- Initial contact and assessment.
- The recipient's eligibility for services.
- Service approval by a psychiatrist or psychologist.
- Development of response plans.
- Development of crisis plans.

Documentation that the recipient is in a crisis or a situation that is likely to develop into a crisis must be sufficient to demonstrate that the conditions outlined at HFS 34.02 (5), Wis. Admin. Code, are met. The provider does not need to separately document this information if it is contained in the initial contact and assessment.

Note : Refer to Section I of this handbook and earlier in this section (Section II) for more information about required documentation for crisis intervention services.

C. Related Limitations

Wisconsin Medicaid does not cover services as crisis intervention services when Wisconsin Medicaid has paid for the same service through another benefit. This includes:

- Alcohol and other drug abuse (AODA) outpatient services.
- AODA day treatment services.
- Case management services.
- Community support program (CSP) services.
- Day treatment or day hospital services.
- Hospital outpatient service.
- Outpatient psychotherapy service.

For example, when the provider helps the recipient find appropriate housing, Wisconsin Medicaid may cover this activity as a covered service under both the crisis intervention benefit and the case management benefit. Assuming all criteria are met, Wisconsin Medicaid will reimburse the provider who is certified in both programs under one of these benefits but not both.

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C. Related Limitations
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Wisconsin Medicaid covers crisis intervention services provided on behalf of Medicaid recipients only and covers crisis intervention contacts with only the following persons:

- The recipient.
- A family member(s), guardian(s), friend(s), or other individual(s) assisting the recipient.
- Professionals, paraprofessionals, or others providing resources required to respond to the crisis.

D. Noncovered Services

Wisconsin Medicaid does not cover the following as crisis intervention services:

- Room and board.
- Volunteer services not meeting the qualifications in HFS 34.21 (3), Wis. Admin. Code.
- Services other than those listed in this section.
- Services that are social or recreational in nature.

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**A. Coordination of
Benefits**

Crisis Intervention and Health Insurance

If the recipient's Medicaid identification card indicates health insurance, providers must seek payment first from the health insurer. If you receive payment from the health insurer, enter the other insurance indicator (OI-P) in element 9 of the HCFA 1500 claim form and indicate the amount in element 29 of the HCFA 1500 claim form. Leave element 9 blank if you do not receive payment from the health insurer.

If no health insurance is indicated on the recipient's Medicaid identification card, do not enter any information in element 9 of the HCFA 1500 claim form.

Refer to Appendix 2 of this handbook for more information about completing HCFA 1500 claims for crisis intervention services.

**B. Medicare/Medicaid
Dual Entitlement**

Dual-entitlees are recipients covered under both Medicare and Wisconsin Medicaid. Since crisis intervention is not a Medicare-covered service, providers should not seek Medicare payment. Therefore, providers must leave element 11 of the HCFA 1500 claim form blank.

**C. QMB-Only
Recipients**

Qualified Medicare Beneficiary Only (QMB-only) recipients are eligible only for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does not cover crisis intervention services, Wisconsin Medicaid does not pay the coinsurance and deductible for crisis intervention services.

D. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a non-Medicaid patient. Providers who do not have a usual and customary charge must bill Wisconsin Medicaid the estimated cost for the service provided. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

**E. Managed Care
Recipients**

Refer to Section I of this handbook for information regarding billing for crisis intervention services provided to recipients who are enrolled in AFDC/Healthy Start HMOs or specialized managed care programs.

**F. Presenting Problem
Codes**

When a recipient has a problem that needs crisis intervention services, these problems are called "presenting problems." Presenting problems are described in four-character codes that identify the presenting problems. Enter presenting problem codes in element 21 of the HCFA 1500 claim form. Providers may enter up to three codes on the claim form. Refer to Appendix 4 of this handbook for allowable presenting problem codes and to Section II of this handbook for more information about covered crisis intervention services.

Presenting problem codes are Medicaid codes. *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) coding structure is not used to identify or describe presenting problem codes.

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- G. Procedure Codes** All HCFA 1500 claim forms require HCFA Common Procedure Coding System (HCPCS) codes. Wisconsin Medicaid denies claims or adjustments received without HCPCS codes. Refer to Appendix 3 of this handbook for allowable HCPCS codes and their description and to Appendix 8 of this handbook for staff qualifications for crisis intervention billing levels.
- H. Quantity** Bill all services in hourly units. Refer to Appendix 6 of this handbook for rounding guidelines.
- I. Place of Service** Refer to Appendix 6 of this handbook for a complete list of allowable place of service (POS) codes. Enter POS codes in element 24b on the HCFA 1500 claim form. Refer to Appendix 2 of this handbook for claim form completion instructions.
- J. Type of Service** For crisis intervention services, the type of service (TOS) is always "1" on the HCFA 1500 claim form. Enter the TOS in element 24c on the HCFA 1500 claim form. Refer to Appendix 2 of this handbook for claim form completion instructions.
- K. Billing for Multiple Staff** When two or more staff are providing services at the same time and using the same procedure code (e.g., W9558 - two "other" staff providing crisis linkage and follow-up), the providers must accumulate their time and bill using only one line on the claim form.

Example of billing for multiple staff: A nurse and a social worker provide three hours of crisis linkage and follow-up together. Appendix 8 of this handbook shows that both of these professionals are at the RN/MS billing level; therefore, these services are both under the same W9557 procedure code. When billing for crisis linkage and follow-up, these staff members must bill under procedure code W9557 for a total of six hours and combine their total charges for these services. All of this information must be entered in the appropriate place on the same line of element 24 on the HCFA 1500 claim form.

L. Claim Submission **Paper Claim Submission**

Submit claims using procedure codes for crisis intervention services on the HCFA 1500 claim form. Wisconsin Medicaid denies claims for crisis intervention services submitted on any other paper form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Neither Wisconsin Medicaid nor the fiscal agent provide the HCFA 1500 claim form. Claim forms are available from many suppliers. One supplier is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
(800) 362-9080 (toll-free)

Mail completed claims for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

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L. Claim Submission
(continued)

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent may process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. All claims that providers submit are subject to the same Medicaid legal requirements. Providers submitting electronically usually reduce their claim submission errors. For more information on paperless claim submission, contact:

EMC Department
EDS
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Claims Submission Deadline

The fiscal agent must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Refer to Section IX of Part A, the all-provider handbook, for exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals.

M. Follow-Up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. The fiscal agent takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good Faith claims filing procedures.